ORAL & MAXILLOFACIAL SURGERY **Hennig, Woodbury & Howard P.C.**

PRIMARY DENTAL **Ins. Name**_____ ID/Subscriber # _____ Group# _____

Insured First Name _____ M.I. ___ Last Name _____ Relation _____

Address _____ City_____ State _____ Zip_____

Date of Birth _____ Soc. Sec. #_____ Home/Cell Phone _____

Employed: ☐Full Time ☐Part Time ☐Retired Employer Phone _____

Employer: _____ Emp. Address_____

SECONDARY DENTAL **Ins. Name**_____ ID/Subscriber # _____ Group# _____

Insured First Name _____ M.I. ___ Last Name _____ Relation _____

Address _____ City_____ State _____ Zip_____

Date of Birth _____ Soc. Sec. #_____ Home/Cell Phone _____

Employed: ☐Full Time ☐Part Time ☐Retired Employer Phone _____

Employer: _____ Emp. Address_____

PRIMARY MEDICAL **Ins. Name**_____ ID/Subscriber # _____ Group# _____

Insured First Name _____ M.I. ___ Last Name _____ Relation _____

Address _____ City_____ State _____ Zip_____

Date of Birth _____ Soc. Sec. #_____ Home/Cell Phone _____

Employed: ☐Full Time ☐Part Time ☐Retired Employer Phone _____

Employer: _____ Emp. Address_____

SECONDARY MEDICAL **Ins. Name**_____ ID/Subscriber # _____ Group# _____

Insured First Name _____ M.I. ___ Last Name _____ Relation _____

Address _____ City_____ State _____ Zip_____

Date of Birth _____ Soc. Sec. #_____ Home/Cell Phone _____

Employed: ☐Full Time ☐Part Time ☐Retired Employer Phone _____

Employer: _____ Emp. Address_____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that I am responsible for any co-pay, deductibles and other fees not covered by my insurance. It is my responsibility to provide the correct insurance information to the provider and if I do not I may be assessed a $10.00 fee if additional forms are needed due to giving incorrect information.

Signature _____ Date _____